PRINTED: 02/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY "D PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495168 B. WING 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB BUENA VISTA, VA 24416 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) E 000 Initial Comments E 000 An unannounced Emergency Preparedness survey was conducted 01/30/18 through 02/01/18. The facility was in substantial compliance with 42 CFR Part 483,73. Requirement for Long-Term Care Facilities. F 000 INITIAL COMMENTS F 000 Shenandoah Valley Health and Rehab An unannounced Medicare/Medicaid standard survey was conducted 01/30/18 through Facility is filing this Plan of Correction for 02/01/18. An extended survey was conducted on purposes of regulatory compliance. The 02/01/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Facility is submitting this Plan of Correction Term Care requirements. to comply with applicable law. The submission of the plan of correction does Substandard Quality of Care was identified in the area of Quality of Care with a Scope and Severity not represent an admission or statement of of Level II, widespread. Two complaints were agreement with respect to the alleged investigated during the survey. The Life Safety Code survey/report will follow. deficiencies. The census in this 93 certified bed facility was 79 at the time of the survey. The survey sample consisted of eighteen current resident reviews and four closed record reviews. F 550 Resident Rights/Exercise of Rights F 550 SS=D CFR(s): 483.10(a)(1)(2)(b)(1)(2) 1. Resident #83 remains in facility. §483.10(a) Resident Rights. The resident has a right to a dignified existence. Resident was provided a cover self-determination, and communication with and for her suprapubic bag during access to persons and services inside and survey. outside the facility, including those specified in

resident in a manner and in an environment that

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each

administrata

(X6) DATE

iency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

this section.

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OF TALE	TO FOR MEDIOARE	CX IVIE	DICKIN SERVICES				<u> </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) Pi	OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER;			DISTRUCTION	(X3) DATE SURVEY COMPLETED
ب			495168	B. WING _			С
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	400100	12: ******		ET ADDRESS, CITY, STATE, ZIP CODE	02/01/2018
SHENAN	IDOAH VALLEY HEAL	TH AN	D REHAB			CATALPA AVE, PO BOX 711	
()(()	: CUMMARY STA	TELIEN	COT DECIDIENAMA		DOE	NA VISTA, VA 24416	
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E 550	Continued From pa	no 1		·			
, 000			enhancement of his or	F 55)O į		
	her quality of life re	nce or	ing each resident's	!	:		
	individuality. The fa	cility m	ust protect and		2.	Residents that have a fol	ley or
	promote the rights of					suprapubic catheter requ	uiring
						bags will have covers pla	
			must provide equal	1	-	These resident have the	
			ardless of diagnosis, syment source. A facility	:			La carla ta
	must establish and	naint:	ain identical policies and			potential to be affected	by this
·]			er, discharge, and the	i :		deficient practice.	,
			er the State plan for all	1	3.	Audits will be completed	during
	residents regardles:					care keeper rounds on re	esidents
	0.650 +0.61 = -			•		with a foley or suprapub	
	§483.10(b) Exercise				•	• • • • •	
•			to exercise his or her facility and as a citizen			catheters to ensure cove	
ر سر	or resident of the U	nited S	racinty and as a citizen. States:	•		place 5x per week for thi	ree
		.,,,,			•	months. Nursing staff w	ill be re-
	§483.10(b)(1) The f	acllity	must ensure that the			educated on dignity and	the use
;	resident can exercis	e his	or her rights without	:		of covers for catheter ba	
_	interference, coerci	on, dis	crimination, or reprisal		4.	Results of audits will be t	-
	from the facility.				4.		
	§483.10(b)(2) The r	esider	it has the right to be			the quarterly Quality Ass	
	free of Interférence,	coerd	ion, discrimination, and			Performance Improvement	ent for
	reprisal from the fac	ility in	exercising his or her	<u> </u>		review and any discrepa	ncies
į			by the facility in the	•		will be corrected immed	iately.
	exercise of his or ne subpart.	er rigni	s as required under this	i	 5.		
		ıt ie ļ	not met as evidenced	:	Э.	Corrective action will be	
	by:	11 15 1	ior mer as evideitêd			completed on March 1, 2	2018.
		on, re	sident interview, staff			•	•
	interview and clinical	i reco	rd review, the facility	-			
	staff failed to promo	te the	dignity of one of 22	; •	•		
			mple. Resident #83	1			
			ection bag without a	<u>:</u> :			i
	privacy cover resulti residents, staff and		collected urine visible to	ŧ			
	residents, Statt and	VISITOR	5				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 84QZ11

Facility (D: VA0223

If continuation sheet Page 2 of 51

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SHENANDOAH VALLEY HEA	LTH AND R			373	EET ADDRESS, CITY, STATE, ZIP CODE 7 CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416	
PREFIX (EACH DEFICIENC	Y MUSIT BE P	DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFI) TAG	(:	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 550 Continued From pa The findings include	. 1		F 5	50		
Resident #83 was 12/26/17 with diag pressure ulcer, hig osteomyelitis. The dated 1/9/18 asses cognitively Intact.	noses that h blood pro minimum	included sacral essure, anemia and data set (MDS)				
bed was a urinary of half full of urine. To with urine visible in room. The resident room at the time of collection bag was	Attached to catheter co he bag had the bag u t had a far the obser observed :	o the lower rail on her bollection bag over do no privacy cover pon entrance to the mily visitor in the vation. The catheter again on 1/30/18 at			·	
12:34 p.m. attache privacy cover. On 1/30/18 at 1:37 interviewed about a collection bag. The have a cover for the been covered since The resident stated covered so her urin	p.m. Resi privacy co resident se bag and she had l	ident #83 was over for her urine stated she did not the bag had not been in the facility, erred to have it				
was admitted with a	ing for Res privacy co LEN #3 different s stocked at was posit	sident #83 was over for the stated the resident shaped collection t the facility. LPN #3 tioned on the bed				
On 1/31/18 at 9:06 in bed with a fabric	a.m., Resi	dent #83 observed : r her urine collection :			•	

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Event ID: 84QZ11

Facility ID: VA0223

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OF DEFICIENCIES OF CORRECTION	(X1) PR	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	l .					E SURVEY IPLETED
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(EACH DEFICIENC	Y MUST 🕏	E PRECEDED BY FULL	ID PREFIX TAG	<	(EACH COR	RECTIVE ACTION SHOU	LDBE	: (X5) : COMPLETION : DATE
bag. Resident #83 about the cover. Repleased with the compleased with the confrom seeing her uri. These findings were administrator and of meeting on 1/31/18 Develop/Impiement CFR(s): 483.21(b)(1) The simplement a complease plan for each president rights set ff §483.10(c)(3), that objectives and time medical, nursing, an eeds that are ident assessment. The confront describe the following (I) The services that or maintain the resiphysical, mental, arrequired under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclusive mental incomplease and time following findings of the PASS about the provide as a result of recommendations. Findings of the PASS about 1982 and 1983 about	was in the cesident over as included in the cesident of the cesident orth at included include	#83 stated she was it prevented everyone e bag. wed with the of nursing during a p.m. rehensive Care Plan e Care Plans must develop and ve person-centered t, consistent with the §483.10(c)(2) and s measurable to meet a resident's tal and psychosocial the comprehensive tensive care plan must be furnished to attain highest practicable hosocial well-being as 483.25 or §483.40; and otherwise be required §483.40 but are not nt's exercise of rights he right to refuse processing facility will ARR lity disagrees with the must indicate its			ren hav cur 2. Res pot ina 3. Edu the Rei the Tea cre to i cor re- DO pla pat	main in the facility we been updated reent plan of care sidents in the facility and itential for an accurate/incomple ucation will be preducted and updated and updated and updated reflect resident's addition. Nursing standard by the DN/Designee on upons to reflect any tient care. Care patient care.	c. Care potential to reflect fitty have ete care povided by esignee to care Place plans and as need overall staff will podating changes ans will lead to the changes and the changes are the	the olan. y o n re ded be care in
				:			•	•
	Continued From particles of the continued From particles of the cover. Regulatory on the cover of the cover o	PROVIDER OR SUPPLIER DOAH VALLEY HEALTH AN SUMMARY STATEMENT (EACH DEPICIENCY MUST E REGULATORY OR LSC IDEN Continued From page 3 bag. Resident #83 was in about the cover. Resident pleased with the cover as from seeing her urine in the These findings were review administrator and director meeting on 1/31/18 at 3:50 Develop/Implement Comp CFR(s): 483.21(b)(1) \$483.21(b) Comprehensiv \$483.21(b)(1) The facility in implement a comprehensiv care plan for each resident resident rights set forth at \$483.21(b)(1) The facility in implement a comprehensiv care plan for each resident resident rights set forth at \$483.10(c)(3), that include objectives and timeframes medical, nursing, and men needs that are identified in assessment. The comprehensiv describe the following - (I) The services that are to or maintain the resident's in physical, mental, and psyc required under §483.24, § GI) Any services that would under §483.10, including the recommendations. If a fact findings of the PASARR, it rationale in the resident's in rationale in the resident's in rationale in the resident's in resident's in resident rights SUMMARY STATEMENT REGULATORY MUST REGULATORY REGULATORY SUMMARY SU	A95168 PROVIDER OR SUPPLIER IDOAH VALLEY HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 bag. Resident #83 was interviewed at this time about the cover. Resident #83 stated she was pleased with the cover as it prevented everyone from seeing her urine in the bag. These findings were reviewed with the administrator and director of nursing during a meeting on 1/31/18 at 3:50 p.m. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) \$483.21(b) Comprehensive Care Plans \$483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	A BUILDI 495168 B, WING, PROVIDER OR SUPPLIER IDOAH VALLEY HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 bag, Resident #83 was interviewed at this time about the cover. 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The comprehensive care plan must describe the following - (1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.24, \$483.25 or \$483.40 and (ii) Any services that would otherwise be required under \$483.24, \$483.25 or \$483.40 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR, it must indicate its rationale in the resident's medical record.	PROVIDER OR SUPPLIER DOAH VALLEY HEALTH AND REHAB SITE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 bag. Resident #83 was interviewed at this time about the cover. 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If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	### PROVIDER OR SUPPLIER DOAH VALLEY HEALTH AND REHAB	PROVIDER OR SUPPLIER DOAH VALLEY HEALTH AND REHAB SIMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY WILT'S BE PRECEDED BY FULL (REGULATIONY ORLS: DENTIFYING INFORMATION) Continued From page 3 bag, Rosident #83 was interviewed at this time about the cover as it prevented everyone from seeing her urine in the bag. These findings were reviewed with the administrator and director of nursing during a meeting on 1/31/18 at 3:30 p.m. CFR(s): 483.21(b)(1) The facility must develop and implement a comprehensive Care Plans \$483.10(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive care plan must describe the following— (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.26 or \$483.40 (b) and (i) Any services that outlid otherwise be required under \$483.26 or \$483.40 (b) and (ii) Any services that would otherwise be required under \$483.26 or \$483.40 (b) and (ii) Any services that would otherwise be required under \$483.10 (c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR, it must indicate its rationals in the resident's medical record.	### A PROVIDER OR SUPPLIER A95168

PRINTED: 02/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PRÓVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495168 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 656 Continued From page 4 F 6561 resident's representative(s)-(A) The resident's goals for admission and the next three months to ensure desired outcomes. they are current and accurate. (B) The resident's preference and potential for 4. Results of audits will be taken to future discharge. Facilities must document whether the resident's desire to return to the the monthly / quarterly Quality community was assessed and any referrals to Assurance Performance local contact agencies and/or other appropriate Improvement for review and reentities, for this purpose. (C) Discharge plans in the comprehensive care education given as needed. plan, as appropriate, in accordance with the 5. Corrective action will be requirements set forth in paragraph (c) of this completed on March 1, 2018. section. This REQUIREMENT Is not met as evidenced Based on staff interview and clinical record review, the facility staff failed to develop and implement a CCP (Compréhensive Care Plan) for three of 22 residents in the survey sample, Resident # 52, # 59 and # 58. The facility staff failed to develop a CCP for Resident # 52 in the area of hearing. 2. Resident #59 dld not have a comprehensive care plan developed to address her vegetarian diet choice or the use of an anticoagulant. 3. Resident #58 had no plan of care developed regarding use of an elastic support dressing applied to the resident's arm for treatment of edema.

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Findings include:. ...

The facility staff falled to develop a CCP for

Resident # 52 in the area of hearing.

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Facility ID: VA0223

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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The resident's clinical record was reviewed and no evidence was found that the resident had any

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Facility ID: VA0223

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NAME OF	PROVIDER OR SUPPLIER					STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
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						BUE	NA VISTA, VA 24416		
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F 656	Continued From pa	ae 6		F	356	Ġ:			
		-	1	1 ();;(3.			
			evices. No evidence						
			esident had seen an						
			pe of consult for the						
			ation was found in the	:					
			to indicate what caused	!					
:		now.	ong the resident had the	:					
	hearing loss.		·	-					
	The resident's CCP	docu	mented, "at risk for						
			ent, blind in L (left) eye,						
	hearing impairment			!		:			
			aring]Hearing and/or						
	vision consultation :	as ne	eded" This CCP was	; !					
-	initiated on 10/01/14	L the	resident's original			į			
			ision date of 01/16/17,	•		;			
, ,			s seen-only a revision			;			
	date.	11 986	a secti-only a revision			į.			
	deto.					: .			
	On 02/01/18 at 10:5	5 41	The ADON was						
:			esident # 52's hearing			:			
1	loss and difficulty co					•			
			stated that the resident			:			
	did not have a heari		d and anid not			:			
	tomombat the regid	ny ai	a and could not	i		1			
	did think that the say	din i	aving one in the past, but t had been tried on an	:					
				:					
			t could not remember			•			
	and would have to k	ok t	hat up. The ADON was						
			s CCP (comprehensive						
	care plan) having m								
			ne resident's extensive	•					•
	nearing loss and no	Info	mation regarding any						ĺ
•	type of assistive hea	ring	devices. The ADON			;			
	was asked if the res					:			
	consultation for heal	ring,	as referenced in the	:		:			
	resident's CCP. The	∌ AD	ON stated that she would			:			
	look for that informa	tion.							
	On 02/01/18 at 11:5	MA C	I, the ADON stated that						
	there was no hearing	3 col	isultation of any kind						

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Event 1D: 64QZ11

Facility ID: VA0223

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	FOF DEFICIENCIES OF CORRECTION	(X1) E	ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY SPLETED
1			495168	B. WING	•		1	C
ļ	PROVIDER OR SUPPLIER	A HT.	ND REHAB		37	TREET ADDRESS, CITY, STATE, ZIP CODE 737 CATALPA AVE, PO BOX 711 UENA VISTA, VA 24416	02/	01/2018
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F 656	Continued From page found for Resident # medical records is leading to the contract of the con	# 52 	and further stated that g.	F 6	56			
	The administrator at was informed on 02 p.m., in a meeting w	/10/1	ON (director of nursing) 8 at approximately 2:30 le survey team.	:				
:	No further information presented prior to the 02/01/18 at 4:00 p.n	e ex	d/or documentation was it conference on	Ĭ	:			
	2. Resident #59 did care plan developed diet choice or the us	to a	nave a comprehensive ddress her vegetarian an anticoagulant.					
	Resident #59 was at 12/15/2017 with the limited to: Major deptract infection, degenerations system, and	follov bress nerati	ving diagnoses, but not ive disorder, urinary ive disease of the					
	The admission MDS assessed Resident # summary score of "1 cognitively intact.	759 a	s having a cognitive			•		
	Resident #59 was in regarding her life at i interview, Resident # vegetarian by choice	the fa #59 st	ewed on 01/30/2018 acility. During the tated that she was a					
·	at approximately 3:00 physician order secti "Lovenox [an anticoa	op.m on wa agular aly on	as an order for nt] 40 mg/0.4 ml Inject e tine a day for DVT		,			

PRINTED: 02/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 495168 B. WING 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 | Continued From page 8 F 656 The care plan was reviewed. There were no Interventions for Resident #59's vegetarian status or information regarding her anticoagulation therapy. The above information was discussed during a meeting on 01/31/2018. The DON [director of : nursing} stated, "We'll get that." On 02/01/2018 the ADON (assistant director of nursing) presented updated care plans for Resident #59. The ADON was asked who updated and developed the care plans. She stated, "Nursing and MDS are responsible for the care plans." No further information was obtained prior to the exit conference on 02/01/2018. . 3. Resident #58 had no plan of care developed regarding use of an elastic support dressing applied to the resident's right arm for treatment of edema. Resident #58 was admitted to the facility on 6/2/17 with a re-admission on 9/21/17. Diagnoses for Resident #58 included high blood pressure, diabetes, hearlt disease, depression, anxiety, history of breast cancer, lymphedema and chronic kidney disease. The minimum data set (MDS) dated 12/27/17 assessed Resident #53 with moderately impaired cognitive skills.

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On 1/31/18 at 8:35 a.m. Resident #58 was observed in her wheelchair with an elastic wrap/bandage covering her right arm. Resident

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	OF DEFICIENCIES OF CORRECTION		PRÓVIDER/SUPPLIER/CLIA			E CONSTRUCTION		TE SURVEY
1			495168	8. WING			n:	C 2/0 1/2018
	PROVIDER OR SUPPLIER	LTH A	ND REHAB		37	TREET ADDRESS, CITY, STATE, ZIP CODE 737 CATALPA AVE, PO BOX 711 UENA VISTA, VA 24416		.70 112 010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	₽E	(X5) COMPLETION DATE
	surgery for breast of therapy applied the each week and was a support "sleeve" arm. Resident #58's clin physician's order differency to evaluate regarding lymphed physician's order differency for experience occupational therapincluded application lymphedema. The resident's planthad no problems, gregarding use of the care plantisted lymphedema but mitto use of the elastic Con 1/31/18 at 8:52 #3) caring for Residence the support wrap with the stated therapy applied the support with the stated the support wrap with the stated therapy applied the support wrap with the stated the support was a support wrap with the stated the support with the stated the support was a support with the support was a support with the support was a support with the support with the support was a support with t	me the eatmost eatmost elast some income inc	ent of swelling following or. Resident #58 stated lic wrap several times king toward ordering her be with the swelling in her be with the swelling in her be with the swelling in her be with the resident and the resident and the right arm. A 1/9/18 documented be times per week that he wrap for treatment of the wrap for treatment of the wrap on her right arm. The sident had a history of the mention or reference sing/wrap. The registered nurse (RN #58 was interviewed the dressing. RN #3 stated treatment of ent's right arm. RN #3 the support dressing. RN why the elastic wrap in the registered nurse in the registered nurse (RN #58 was interviewed the support dressing. RN #3 the support dressing. RN why the elastic wrap		\$56			
	nurse (LPN #1) res plans was interview wrap. LPN #1 look stated she did not s	ponsi red al ed thi see al	the licensed practical ble for MDS and care bout Resident #58's arm rough the care plan and hything on the care plan ng. LPN #1 stated					

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	OF DEFICIENCIES OF CORRECTION	(X1) PI	OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP O		10 1120 10
SHENAN	IDOAH VALLEY HEA	ነጥሬ ለእ	n peusp	3	3737 CATALPA AVE, PO BOX 711		
OHERAN	DOMI VALLE (I)EA	EHIAN	CIAG	E	BUENA VISTA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST I	OF DEFICIENCIES BE FRECEDED BY FULL TIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	Continued From pa	-		F 656			
	. therapy applied the	wrap 1	o the resident's arm.				
	interviewed. The 0 seen three times p	cared : OT state er wee	for Resident #58 was ed Resident #58 was k for treatment of				·
	support wrap had to swelling in the resi	oe <mark>en s</mark> u dent's a	rm. The OT stated the increaseful in reducing arm. The OT stated she erapy concerning the				•
	wrap. The OT stat to the nursing staff and participated in	ed she about daily n OT state	communicated weekly the resident's progress eetings with the MDS ed she did not know why				
	interdisciplinary pla These findings wer	n of ca e revie	re for Resident #58. wed with the		;	,	
:	meeting on 1/31/18	JIFECTOR 3 st 3.5	of nursing during a				
F 657	Care Plan Timing a CFR(s): 483.21(b)(and Rev	vision	F 657	·		. -
	be- (i) Developed within the comprehensive	mprehe n 7 day asses Interdis	ensive care plan must s after completion of sment. sciplinary team, that	•	 Residents #8, #25, #5 #60 remain in the fac plans have been upda reflect current plan o Residents in the facili potential for an 	ility. Care ated to f care.	
:	(A) The attending p(B) A registered nu resident.(C) A nurse aide wi resident.	hysicie rse witi th resp	n. n responsibility for the		inaccurate/incomplet	te care plan.	
DRM CMS-25	(E) To the extent pr	acticat e resid	ple, the participation of ent's representative(s). Event ID:640Z11	Fa	isitity ID: VA0223	Continuation shee	

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	STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CON	(×	(X3) DATE SURVEY COMPLETED	
			495168	8. WING_				C 02/01/2018
	PROVIDER OR SUPPLIER	LTH ANI	REHAB	:	3737 Ç	TADDRESS, CITY, STATE, ZIP CODE NATALPA AVE, PO BOX 711 A VISTA, VA 24416		02/01/2018
(X4) ID PREF:X TAG	(EACH DEFICIENC)	Y MUST 8	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX YAG	Flat to Abato (1.)	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) E COMPLETION TE DATE
F 657	medical record if the and their resident resident resident's care plan (F) Other appropriated disciplines as deteror as requested by (iii)Reviewed and reteam after each as comprehensive and assessments. This REQUIREMED by: Based on, staff Interview, the facility a comprehensive cresidents, Resident 1. Resident (R 25) include Intervention behaviors.	st be in- te particle the device. In the staff the res evised the sessmed quarte NT is n erview a staff fail are plants care plants regar failed to #59's	or professionals in by the resident's needs ident. by the interdisciplinary int, including both the rly review of met as evidenced and clinical record ed to review and revise in for five of 22 #59, #60, #8, and #51. an was not revised to ding mood and or remove foley catheter are plan after the		3.	Education will be provided the VP of Clinical Reimbursement / designs the Interdisciplinary Car Team to ensure care platereated and updated as to reflect resident's overcondition. Nursing staff re-educated by the DON/Designee on update plans to reflect any char patient care. Care plans audited weekly following routine care plan scheduled the next three months to they are current and accordinate to faudits will be the monthly / quarterly Assurance Performance	nee to re Plan resonanced rall will b ting conges in will b g the ule ov o ensi- curate taken	ed ed are e er ure
	3. Facility staff faile therapy and lab wor #60's care plan after discontinued.	rk (PT/(NR) from Resident	:	5.	Improvement for review education given as need Corrective action will be	ed.	re- ·
		ve care	date Resident #8's plan) to include this her health status.		:	completed on March 1, 2	2018.	· i'
:	5. Resident 51's ca include care and tre sore.	are plan eatmen	was not revised to tor a new pressure					·

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	TOF DEFICIENCIÉS OF CORRECTION		PRÓVIDER/SUPPLIER/CLIA PENTIFICATION NUMB E R:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
1		495168	B. WING			C 02/01/2018		
	PROVIDER OR SUPPLIER	LTH A	ND REHAB		3737	EET ADDRESS, CITY, STATE, ZIP CODE 7 CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416	-	7 1 1 2 1 3
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
	include intervention behaviors. 1. R 25 was admitt with diagnoses that The most recent M quarterly assessment reference date) of as being moderated R 25's electronic reR 25's care plan refor mood and behavion bativeness, yell disorder and psychmedications. Accommedications.	care is reg red to inclu DS (nent with 1/22/ y cog cord view covior with ling of totropic	plan was not revised to arding mood and the facility on 1/25/12 ded depression. ninimum data set) was a h an ARD (assessment 17. R 25 was assessed nitively impaired. was reviewed on 1/31/18. documented a care plan ith a history of refusals, ut related to depression c and antidepressant	F	557	DEFICIENCY		
	redirection prompts activities (not specific this care plan only in review medications). On 02/01/18 08:14 MDS coordinator (Leoncerning the care and behavior interventions and agreement of the content of the care and agreement of the care and agreement on the care and agreement of the care agreement of the ca	did no and fic). (nolud AM L PN # plan entior greed ssed	ot include diversional or only generalizing 1:1 Other interventions for ed, give, monitor, and icense practical nurse, 1) was interviewed regarding altered mood is. LPN #1 reviewed that the care plan and updated to include					

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AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PRO	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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SHENAN	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT 3737 CATALPA AVE, PO BOX BUENA VISTA, VA 24416		02/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE	OF DEFICIENCIES I PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPI	BE COMPLETION
	and administrator diadministrator diadministrator did not administrator did not not administrator did not	m. the a tion of the uring a rot common was part to the continued following pressive in the facility of p.m. The rotage of the correction was corrected to the correction of the corre	he director of nursing meeting. The DON or ent. presented prior to exit remove Foley t #59's care plan after ed. to the facility on a diagnoses, but not e disorder, urinary disease of the yroidism. um data set) having a cognitive cating she was ed on 01/30/2018 ity. During the ed that when she a catheter but the pladder training and eved on 01/30/2018 The care plan was rentions for Resident cluding but not limited f catheter bag every shift.	F 68			
ORM CMS-2561	7(02-99) Previous Versions C	bsolete	Event ID:64QZ11	-	acility ID: VA0223	If continuatio	n sheet Page 14 of 51

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	OF DEFICIENCIES OF CORRECTION		ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	TH AI	VD REHAB	·	3737	EET ADDRESS, CITY, STATE, ZIP CODE 7 CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416	02/01/2018
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	was asked when the off of the care panal stated, "When it was on 02/01/2018 the nursing) presented Resident #59. The updated and development of the care plans."	018. e cath The s disc ADON updat ADON ped t d MDS	The administrative team eter should have come DON [director of nursing] continued." I (assistant director of ed care plans for N was asked who he care plans. She S are responsible for the es obtained prior to the	F 6	57		
	#60's care plan after discontinued. Resident #60 was con 04/19/16 and readiagnoses including (end stage renal distribution, Pneumoni Diabetes, Hypertens The most recent MI significant change a (assessment refere Resident #60 was a with a total cognitive	k (PT r the rigina admitt i, but ease pirato a, Uri alon, DS (m esses nce d ssess scor	/INR) from Resident medication was ally admitted to the facility ed on 12/22/17 with not limited to: ESRD prepared by Failure, Pleural nary Retention, Anxiety and Depression. In imum data set) was a sment with an ARD ate) of 12/29/17.				
:	01/30/18 at approximation of the CCP at	natel in inte					

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	I OF DEFICIENCIES OF CORRECTION		ÖVİDER/SUPPLIER/ÇLIA NTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
			49 5 168	B. WING _		C 92/04/0047
	PROVIDER OR SUPPLIER	TH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416	02/01/20 <u>18</u>
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	MUST BE	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 657	Subsequent review MAR (medication as survey dates of 01/3 showed this medication discontinued. The Creflect these change care (POC). The ADON (assistation interviewed on 02/0 a.m. regarding who the CCP. The ADO all departments can were Informed of the meeting with the sur approximately 2:05	of the production was a control of the production and compared to the control of	chysician orders and ration sheet) for the trough 02/01/18 d labs had been id not been updated to esident #60's plan of tor of nursing) was approximately 11:54 onsible for updating d, "Mostly nursing, but of themselves." N (director of nursing) arm on 02/01/18 at of further information team prior to the exit	F 0 s	57	
	resident's overall de Resident #8 was orig on 09/22/14 and rea	cline in ginally a dmitted but no ormal po brovasce and Ho	her health status. admitted to the facility of the control of the			
:		ent with	an ARD (assessment		•	

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STATEMENT AND-PLANC	OF DEFICIENCIES F CORRECTION		RÓVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER DOAH VALLEY HEAL	TH AN	ID REHAB		373	REET ADDRESS, CITY, STATE, ZIP CODE 7 CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416	1 02	101/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST	T OF DEFICIENCIES BE PRECEDED BY FULL IMITYING INFORMATION)	ID PREFI TAG	ς .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRESION (CROSS-REFERENCE)	DBE	(X5) COMPLETION DAYE
F 657	assessed as severe long term memory a skills. Throughout the sun Resident #8 was ob positioned side to a mattress. Resident quarter siderails in peach palm. The clinical record on 01/31/18 at 8:30 CCP (comprehensive following intervention items available and reacher. Footwear ADL's [activities of conceded. Assure pare mealtime if needed. Care. Feeds self aff [percentage] consum Oral care assistance involve me in out of watching" in the sm. Review of Resident 11/01/17 indicated the series of the ser	vey 01 serve de wir #8 hablace of Res a.m. resident is Encorated to promise as normall day #8's and serve as normall day #8's	paired in her short and aily decision making /30/18 through 02/01/18 d lying in bed, th pillows and a concave ad her eyes closed, and folded washcloths in eldent #8 was reviewed Review of Resident #8's e plan) included theCall light or personal sy reach or provide vide slipping. Assist in ving) and mobility as a monitored during purage choices with eal setup; monitor % weight per protocol. eededContinue to activities like "people proom"	F 6	57	DEFICIENCY)		
:	(range of motion) in #8 was totally deper including dressing, e	all for ident eating	ur extremities. Resident		:			
:	any of the deficits m (assistant director o	ention f nurs	ever updated to include ned above. The ADON ing) was interviewed on v 11:54 a.m. regarding					

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	OF DEFICIENCIES OF CORRECTION		ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(хз) DATE SURVEY COMPLETED
r \ \ \ \ \			495168	B. WING				C 02/01/20 18
	PROVIDER OR SUPPLIER	LTH A	ND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BÓX 711 BUENA VISTA, VA 24416			
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	ADON stated, "Mo departments can use the administrator were informed of the meeting with the stapproximately 2:05 was received by the conference on 02/05. Resident 51's conclude care and the sore. Resident #51 was 3/9/17 with diagnoss schizoaffective disconference and the sore. Resident #51's clin conference and the sore. Resident #51's clin conference and the sore. Resident #51's clin conference and the series assessed Resident was assessed with the latest was assessed was assessed with the latest was assessed was assessed was assessed with the latest was assessed was asses	for upstly nupdate and Done about p.m. e survey f. 1/18. are place admitted by the p.m. for the property of the p.m., wounding children and p.m., wounding childre	dating the CCP. The rising, but all for themselves." ON (director of nursing) we Information during a seam on 02/01/18 at No further information ey team prior to the exit an was not revised to ent for a new pressure ded to the facility on at included panic disorder, anxiety, we pulmonary disease), bod pressure. The dated 12/20/17 as cognitively intact. Incord documented a 18 stating the resident source ulcer on her right ented a physician's order ent to the resident's right wound cleanser and a the registered nurse (RN d care was observed ange to a pressure ulcer	F 6	57			
	Resident #51's plan	ofca	ire (print date 1/31/18)	!				

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	OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	í		ONSTRUCT				E SURVEY PLETED
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	PROVIDER OR SUPPLIER IDOAH VALLEY HEAI		D REHAB		3737	STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416				
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F 684	documented the redeveloping pressur mobility and a history intervention. The resident pressure ulcer on the control of the con	sident re ulcer ory of sident's cany proding the he righ 6 a.m., ponsible arterly onsible olems are per erevietirector	s due to decreased bed kin tears and skin are plan was not blems, goals and/or a newly developed theel. the licensed practical le for MDS and care erviewed about LPN #1 stated there lan about the right heel routinely updated care review and the unit for revising care plans and/or issues occurred. wed with the of nursing during a	F6	884					
	applies to all treatm facility residents. Bassessment of a re that residents recei accordance with propractice, the compricate plan, and the right REQUIREMENT by: Based on staff interested in the record of the r	fundar nent an ased o sident, ve trea ofessio rehensi residen VT is r review, review,	n the comprehensive the facility must ensure tment and care in nal standards of ve person-centered		·	2.	Resident #60 refacility. Resident updated to refulid restriction Residents in threstriction have be effected by practice. An aucompleted on residents with to ensure order	ent's ord flect resion of during he facility we the po withis def Judit was 2/01/20 fluid res	er was dent's survey on flu tential icient 18 of	id to
ORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 64QZ1	1	Facility	(ID: VA0223		Fanction ===		



STATEMENT OF DEFICIENCIES	(X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	i	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLISHENANDOAH VALLEY H		REHAB		STREET ADDRESS, CITY, STATE, 2 3737 CATALPA AVE, PO BOX 71 BUENA VISTA, VA 24416	ZIP CODE
PREFIX (EACH DEFICE	ENCY MUST 6	OF DEFICIENCIES É PRECEDED BY FULL JEYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 684 Continued From one of 22 resident #60.	· -	survey sample,	F 68	4	: ,
Resident #60's period as order Findings includ Resident #60 won 04/19/16 and diagnoses includend stage rend (hemodialysis), Effusion, Pneuro Diabetes, Hype The most recersignificant chard (assessment received assessment received assessment received assessment received as a period (patient) fluid in hours max [material fluid in hou	fluid intake ed by the p ed: //as originall d readmitte iding, but not al disease) // Respirator monia, Urin intension, Al ministration order sheet in the source in the	y admitted to the facility d on 12/22/17 with of limited to: ESRD requiring HD y Failure, Pleural ary Retention, exiety and Depression. Imum data set) was a nent with an ARD te) of 12/29/17. Id as cognitively intact of 13 out of 15. In dated 02/01/18 or: "monitor pt. [ounces] q [every] 24 ke. every shift" (sic) January 2018 MAR sheet) included the shifted restriction, but	The same of the sa	educated on h for fluid restrict be completed months to ens allocated has be appropriate do provided on M 4. Results of aud the monthly/of Assurance Per Improvement review. 5. Corrective ac	oeen given with ocumentation IAR. It will be taken to quarterly Quality formance Committee for
shift. No fluid in the MAR per sh	ntake amou lift. The Ta gain showe estrictions.	in the box for each nt was documented on sk screen was also d only checks in the	•	Facility ID: VA0223	

	OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION			E SURVEY IPLETED
		4	95168	B. WING					C 01/2018
NAME OF	PROVIDER OR SUPPLIER				STR	EET ADDRESS, CITY, STATE, ZIP C	ODE	 -	
SHENAN	IDOAH VALLEY HEAI	LTH AND REH	AB.		373	7 CATALPA AVE, PO BOX 711			
O I I C I I					BUI	ENA VISTA, VA 24416			
(X4) ID PREFIX TAG	ŞUMMARY STA (BACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-RÉFÉRENCED TO THE DEFICIENCY)	SHOULD	BE	(XS) COMPLETION DATE
					• [
F 684	Continued From pa	1	•	FE	84				
	On 02/01/18 at 11:0	50 a.m. the Al	DON (assistant						
Ì	director of nursing)								
	documentation of fl physician ordered f			;					
ľ	stated, "We don't h			:		9			
	limits per meals an								
	physician order is u								
	the limits per shift."			:	i				
	p.m., We do not ha					-			
	record fluid intake r					•			
	order breaking dow shift."	ni nis nuiu res	unctions per						
	: :	-							
	The Administrator a	and DON (dire	ector of nursing)	ì					
	were informed of th								
	meeting with the su			•					
	approximately 2:05			i					
	was received by the		prior to the exit		:				
E 686	conference on 02/0 Treatment/Devices		I m m ni (\) / (-1						
	CFR(s): 483.25(a)(iearing/vision		885				
J 39-D	Or 11(0). 100.20(a)(1//2/		: . –		0		. ماللم	
	§483.25(a) Vision a	and hearing			1.	Resident #52 remai		,	
	To ensure that resid	dents receive	proper treatment	Í		Facility contacted re	espons	ible	
	and assistive device			}		party on 2/15/18 to	obtair	ı	
	hearing abilities, the assist the resident-		, if necessary,	•		consent to send res	ident o	out of	
	assist the resident-					facility to audiologi	st for c	onsult.	
	§483.25(a)(1) In ma	aking appoint	ກents. and			Resident's family d			•
						·			
	§483.25(a)(2) By ar			-		resident has hearin			
	and from the office					home but in the pa	st has i	refused	d
	the treatment of vis			!		to wear. Responsit	ole part	:γ	
	the office of a profe provision of vision of			:		stated she will brin	g heari	ng aids	3
	This REQUIREMEN				•	into facility for faci	-	_	
	by:		5.5 6774 6770 64				•		
	Based on observat	tion, resident i	interview, staff			resident with them	again.		
			•		;				
FORM CMS-25	67(02-99) Previous Versions	Obsoleje	Event ID:64QZ	i1	Facilit	y ID: VA0223 If	ac atlau at		Pone 21 of 51

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		VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	(X3) DATE SURVEY. COMPLETED		
			495168	B. WING			1	C 01/2018	
		TEMENT C	REHAB F DEFICIENCIES PRECEDED BY FULL	lb PREF	373; BUI	EET ADDRESS, CITY, STATE, ZIP CODE CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL			
TAG			YING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE	
	staff failed ensure of survey sample received a hearing loss for Re The facility staff fall 52 received a hearing address the resident # 52 was 10/01/14 with diagrous to: major depression high blood pressure retention. The resident ensurement of the most current of the most current of the most current of "3", indicating the impaired in daily decresident was also a having moderate of having/using a hear on 1/30/18 at 10: the facility, Resider room laying in bed. In the facility of the second of the respond. The second of the respond. The resident was also a having moderate of the facility of the facility of the facility of the second respond. The second of the respond. The resident area, but did not recloser and spoke in the facility of the resident was also at the facility of the facility of the resident of the respond. The residence and spoke in the survey of the residence and spoke in the facility of the faci	al record one of 22 sived car sident # ed to en ng evaluate signification of the constant of t	e and/or services for 52. sure that Resident # lation and/or consult to ficant hearing loss. It to the facility on cluding, but not limited der, anxiety disorder, hyroidism, and urinary not have an actual sted on the resident's lan's order set). Inimum data set) was a stal/20/17. This MDS aving a cognitive score at was severely taking skills. The lon this MDS, as earing and not for device. Iduring the initial tour of as observed in her urveyor knocked on the le in. The resident did is done, with a louder of the resident did not looking at the door. The surveyor moved			Residents in the facilitic identified with hearing the potential to be affective this deficient practice. An audit will be conducted identify residents with impairment. Resident identified will have concobtained and if applica audiology consults will scheduled. Nursing streeducated on 2/21/202 social services of any with suspected hearing Social services will the responsible party to a hearing loss and schedupointments if desired. Results of audits will be the monthly/ quarter Assurance Performan Improvement for revision Corrective action will be completed on March 2	cted to cted to hearing s nsents able, l be aff were 18 to noti resident ig loss. en contact ddress dule ed. be taken t ly Quality ce ew.	fy t	
y	on the side of the b			· •	; i.			;	

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Event ID: 84QZ11

Facility ID: VA0223

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	T OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MU A. BUIL		LÉ CONSTRUCTION		(X3) DATE SURVEY COMPLETED
			495168	B. WING	}			C 02/01/2018
	PROVIDER OR SUPPLIER	_TH ANI	D REHAB		3	STREET ADDRESS, CITY, STATE, ZIP COI 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416	DE	V2/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST B	OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE COMPLETION
F 685	could not hear wha : : : 02/01/18 08:04 AM the day room area	ery louc t was b the re- close to	sident was observed in the nursing station	F	685			
	w/c, the resident ware resident is is very h	as spok IOH (ha						
\sim	no evidence was for type of hearing aids could be found that audiologist or had a hearing loss. No in resident's clinical re	und the or dev the res iny type formation	ident had seen an of consult for the					
	fallscognition imp hearing impairment statusHOH [hard vision consultation : initiated on 10/01/1/ admission and has	airment impa of heari as need 4, the re a revisi	ing]Hearing and/or led" This CCP was					
:	loss and difficulty conhearing loss. The Add not have a hearing remember the residudid think that the resamplifier at one point.	ng Resommuni NDON sing aid a ent have sident hat nt, but s	ident # 52's hearing cating due to the tated that the resident					
DRM CMS-2567(02-99) Previous Versions Obsolete		Event ID: 64QZ11		Fa	dility ID; VA0223 If cor	- htinuatio	n shoet Page 23 of 51	

	OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA STIFICATION NUMBER:	i	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			495168	B, WING			C 02/01/2018			
	PROVIDER OR SUPPLIER	TH AND	REHAB		STREET ADDRESS, CI 3737 CATALPA AVE, BUENA VISTA, VA	PO BOX 711	i veloneold			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	' MUST BI	OF DEFICIENCIES E PRECEDED BY FULL JEYING INFORMATION)	ID PREFIX TAG	(EACH CORF	RS PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION			
F 689 \$\$=D	care plan) having minterventions regard hearing loss and not type of assistive he was asked if the resconsultation for hearesident's CCP. The look for that information of the administrator as were informed on the administrator as were informed on the properties of the administrator as were informed on the properties of the administrator as were informed on the properties of the aring loss and the documentation could clinical records to in the aring loss had be not further information presented prior to the theorem of the properties of the properties of the properties of the facility must en \$483.25(d) (1) The mas free of accident the \$483.25(d)(2) Each 198483.25(d)(2) Each	dent's (inimal) dent's (inimal) dent's (inimal) dent's (inimal) dent's d	resident's extensive ation regarding any evices. The ADON ad any type of referenced in the N stated that she would the ADON stated that ultation of any kind d further stated that N (director of nursing) at approximately 2:30 survey tearn of F Resident # 52's formation and/or cated in the resident's that the resident's ressed. For documentation was conference on Supervision/Devices	F6	89					
FORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID:84QZ11		Facility ID: VA0223	If continua	If continuation sheet Page 24 of 51			

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- CO COL 1 1 1 1 1 1	(O) OK MEDIONINE		I OF THE CENT OF THE CENT				1	7
	OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		SURVEY.
			4951 6 8	B. WING			02/0) 1/2018
NAME OF	PROVIDER OR SUPPLIER	10 , 7, 7			STDE	ET ADDRESS, CITY, STATE, ZIP CODE	. 024	TIEUTO
	IDOAH VALLEY HEAL	TH AND	REHAB		3737	GATALPA AVE, PO BOX 711 NA VISTA, VA 24416		
						, <u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	A TRUM	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	38E i	(X5) COMPLETION DATE
F 689	by: Based on observat interview and clinic	NT is n lon, res al recor	ot met as evidenced sident interview, staff d review, the facility e room environment for	- -	1.	Residents #51, #58, and #83 in the facility. The loose be	drail for	
	staff failed to ensure a safe room environment three of 22 residents in the survey sample. Resident #51 had a loose bed rail and the bed control remote cable was in disrepair with exposed wiring. The right brake had an expose rough tip on Resident #58's wheelchair due to missing handle and her bed control remote ca had exposed wiring. The bed remote cable fo Resident #83 was in disrepair with wiring exposed.					resident #51 was repaired during survey. The wheelchair brake for resident #58 has been repaired. Bed controls for Residents #51, #58, and #83 with cracked, protective outer coating were repaired during survey. Audits were completed of bed		I
	the cable to the bed exposed wiring. Resident #51 was a 3/9/17 with diagnos schizoaffective disc COPD (chronic obs tibia fracture and hi minimum data set (assessed Resident	as using dremot admitted es that wider, p tructive gh bloc MDS) of #51 as z.m., tesiden	included anic disorder, anxiety, a pulmonary disease), of pressure. The dated 12/20/17 cognitively intact. Resident #51 was t #51 grabbed the left		2	controls and repaired by use electrical tape to cover. Bed identified with controls have cracked, protective outer or were repaired and an order placed for new controls. Replacement controls have received in facility and main currently replacing controls. Bedrails, bed controls, and wheelchairs in the facility his potential to be affected by deficient practice. Bedrails	ds ing pating was been ntenance ave the this , bed	e
	positioning. The let back and forth as the on the rail. In addit control remote was wiring visible throug the cable covering.	It bed reside reside ion, the in disresion in disresion in the individual individual in the individual in	ail was loose, moving dent pressed and pulled cable to the bed epair with multi-colored en, missing sections of	A PART OF THE PART		controls, and wheelchairs in facility will be assessed by Maintenance to identify an or adjustments.		5

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	OF DEFICIENCIES F CORRECTION	(X1) Pi	OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		NSTRUCTION		SURVEY
			495168	B. WING			07/	-
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			TREE	T ADDRESS, CITY, STATE, ZIP CODE	1 02/0	1/2018
SHENAN	DOAH VALLEY HEAL	TH AN	D REHAB	1		CATALPA AVE, PO BOX 711 NA VISTA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST	OF DEFICIENCIES SE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE '	(X5) COMPLETION DATE
F 689	Continued From pa	ge 25		· F 689				,
	the exposed wiring, used the rails to reprotect aware of the wire control cable. On 1/30/18 at 11:27 nurse (LPN # #3) cashown the loose rail was interviewed ab LPN #3 stated main rooms and make a stated work orders for items needing rewould report the loose the maintenance difference was interviewed ab LPN #3 stated main report the loose bed rail and eremote. The maintenance difference rated residence to be tighted director stated residered to be tighted director stated exponence cables around cracks to the cable director stated exponence resident because the voltage. The main repaired the bed caperform routine main these findings were f	Residence of the control of the cont	the licensed practical or Resident #51 was exposed wires. LPN #3 items in disrepair. ce used to go through eeded repairs. LPN #3 upposed to be written LPN #3 stated she and exposed wiring to he maintenance about Resident #51's d wiring on the bed director stated as loose from use and he maintenance ended to wrap the bed bed rails resulting in hg. The maintenance ires underneath the hd the remotes were hance director stated the ented little risk to the elremote was "low se director stated he hen reported but did not not on the bed remotes. wed with the of nursing during a		3.	Education will be provided be DNS/designee to report loos bedrails/damaged bed contraints and rods to Mainten for repair and adjustments. A will be done 5x weekly during Keeper Rounds to ensure be are not loose and bed contrainthout cracked, protective accoating. Audits will be conditioned the shower team weekly to express the brake handles and rods are in Maintenance will complete audits on beds to identify a with cracked protective outloose side rails need to coating, loose side rails need to coating, loose side rails need to Quality Assurance for rewith appropriate recommendate. These audits will be and the QAPI committee refor ongoing compliance. Date of completion March	ols and ir brake lance Audits g Care drails are outer ucted be ensure in place emonth controls ter eding chair be take view are endation esponsil	y ly en ed ns eg pie
:								

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/16/2018 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION		VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
			495168	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER			1 <u>-</u>	STREET ADDRESS, CITY, STATE, ZIP CO	3DE	02/	01/2018
	DOAH VALLEY HEAI	TH AND	REHAB		3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24418	737 CATALPA AVE, PO BOX 711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 689	2. The right brake r on Resident #58's v handle. Resident # had exposed wiring Resident #58 was a 6/2/17 with a re-adr Diagnoses for Resi pressure, diabetes, anxiety, history of b	od had a vheelcha 58's bed	control remote cable to the facility on n 9/21/17. included high blood sease, depression, noer, lymphedema The minimum data	F6	89			
	room. The right bra wheelchair had an of missing handle cov- pieces of pink foam the rod. Resident # time about the miss resident stated the someone taped the her to use as a han	eelchair sake on the exposed, er. The taped to 58 was ing brake handle gifoam piedle. The	self-propelling in her e resident's rough tip due to a orake rod had two the middle section of nterviewed at this e handle. The					
	director came in the observation and cov tape. The maintena at this time about th wires. The mainten	bserved ed wiring room at vered the ince dire e broker ance dire es were ne was o	with a cracked The maintenance the time of this broken cable with ctor was interviewed cable and exposed ector stated some of cracked/broken with					

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Facility (D: VA0223

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	OF DEFICIENCIES F CORRECTION		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	1 -	TIPLE CONSTRUCTION NG		TE SURVEY
			495168	B. WING_		۰	C 2/01/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	10112010
CHENAN	DOAH VALLEY HEAL	TU ANU	DEUAD	ĺ	3737 CATALPA AVE, PO BOX 711		
SHENAN	DUAN VALLET NEAL	.in Aivi	KENAS		BUENA VISTA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST B	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 27		. F6	89		
!	registered nurse (R the missing brake h RN #3 was interview rough brake rod and stated, "Looks like s fix on it [handle]." Fitherapy was responding the brake handle needed a "p	N #3) of andie of andie of andie of andiesis someon RN #3 significant and are remanderiewed and andiesis andi	ng handle. RN #3 he just put a temporary itated she thought or replacing the missing hd stated the brake ent fix."				
	3. The bed control of disrepair with wiring		or Resident #83 was in ed.				
:	Resident #83 was a 12/26/17 with diagn pressure ulcer, high osteomyelitis. The dated 1/9/18 assess cognitively intact.	oses tř blood minimu	at included sacral pressure, anemia and im data set (MDS)			·	:
	tape. Resident #83 about the bed remo the bed control remobroken in places wite exposed. Resident still working but "You Resident #83 stated	section te was was in te cabl ote cab h the r #83 st u could	of cable to the covered with repair terviewed at this time e. Resident #83 stated ble covering was nulti-color wires ated the remote was				

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			OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			495168	B. WING		C 02/04/2045		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		2/01/2018		
SHENA	SHENANDOAH VALLEY HEALTH AND		REHAB		3737 CATALPA AVE, PO BOX 711			
					BUENA VISTA, VA 24416			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOWS OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPLICATION CROSS-REFERENCED TO THE APPLICATION CROSS			HOULD BE	(Xs) COMPLETION DAYE		
F 689	Continued From pa	age 28		F 689				
	on the bed remotes stated residents ter cables around the the cable covering, stated exposed wire were insulated and working. The main broken cable cover resident because the voltage." The main repaired the bed caperform routine main these findings were administrator and dimeeting on 2/1/18 a	ewed at a the moded to be a rails the remarks presented tenance the cable tenance with the remarks presentenance the same a review irector of the same a review a rev	cout the exposed wiring maintenance director wrap the bed remote a resulting in cracks to aintenance director rneath the covering notes were still a director stated the inted little risk to the elemente was "low a director stated he en reported but did not be on the bed remotes."					
	Bedrails CFR(s): 483.25(n)(:	F 700				
	a bed or side rail is	empt to installin used, th use, and	g a side or bed rail. If he facility must ensure he maintenance of bed		1. Resident #51 remains in Bedrails for resident #51 repaired during survey. #5, #6, #8, #25, #36, #51, #58, #59, #60, #63, #83, remain in the facility. Th	was Residents #52, #56, and #287		
	§483.25(п)(1) Asserting the second se	d rails p w the ris	orior to installation. sks and benefits of	·	identified at risk of entra be assessed for replacem repaired. Extenders or p devices to correct identif have been ordered to res identified safety issues.	pment will ent and/or roper ied space		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	. & MED	CAID SERVICES			<u>`</u>	MB NO. 0938-0391		
		VIOER/SUPPLIER/CLIA TIFICATION NUMBER:	(XX) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED				
	s.:		495168	B. WIÑG			C		
NAME OF	PROVIDER OR SUPPLIER		1			TADDRESS, CITY, STATE, ZIP CODE	02/01/2018		
				1		ATALPA AVE, PO BOX 711			
SHENAN	idoah valley heai	TH AND	REHAB			A VISTA, VA. 24416			
	CUMBIANTY CTA	TERITORY	T DEPARTMENT	<u>,</u>					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE	of deficiencies Preceded by full. Fying information)	ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY).					
F 700	Continued From pa	ge 29		· - F74	00				
		-	he bed's dimensions	٠					
			dent's size and weight.	Į.	2.	Beds with rails in the facilit	•		
	,			:		the potential to be affected	by this		
	: §483.25(п)(4) Follo					deficient practice. Beds with	th rails in		
	recommendations and spe and maintaining bed rails.		citications for installing	!		this facility will be assessed			
	. and marketting be . This REOUREME!	u rans. ÚT is no	t met as evidenced			Maintenance to Identify en			
	by:	11 10 //	, mor do ovidendes			•	trapment : :		
i 1	Based on observat		ff interview, facility	•		potential.			
	document review a	nd clinic	al record review, the	i.	3.	Residents' beds will be inspected for			
	facility staff falled to assess interventions to ensure safe		and/or implement			safe operation, risk of entra	apment,		
	throughout the facil	iure sale liv for 1:	s oco rail use 3 of 18 current			for comfort and potential for other			
	residents in the sur	vev sam	ple (Residents #5, #6,	I		adverse events. Maintenan			
	: #7, #8, #25, #35, #3	36, #42,	#51, #52, #56, #58,	<u>!</u>					
	#59, #60, #61, #63,	#83 an	d #287.) This resulted	1		conduct a monthly inspecti			
	in the identification	of subst	andard quality of care.	:		bedrails in use to ensure be	ed rails		
	Overall, bed rall assessmen		nta cafethints with 10001	-		are securely attached to be	d frame		
			is of entrapment due	i		along with the inspection o	f		
	to gap measureme	nts bevo	ind those	1		electronic bed controls. Be			
	recommended by the	he Food	and Drug						
	Administration (FD.	A). The	e were no			tracking will be completed	•		
	interventions imple	mented	in response to the	:		(electronic maintenance lo	gs). Staff		
	assessments to minimize a entrapment risks from the tincluded the beds for Resident			1		will be educated on immed	iate		
			PECITARS, IMS Pents #6 #7 #60 #66	!		reporting of any identified	loose hed		
	#59, #60, #61, #63			:		rails.			
	. , , ,			:					
) beds in the facility	:	4,	Results of audits will be tak			
			apment risks, This	:		monthly/quarterly Quality_			
			lents #5, #8, #25, #35,	;		committee responsible for			
	#36, #42, #51, #58,	and #o	Ģ.			ongoing compliance.			
:	1	ļ				_ <u> </u>	· · · · · · · · · · · · · · · · · · ·		
	The findings include	ä:			5.	•			
	g					completed on March 1,	2018.		
	On 1/30/18 at 11:17				:				
	observed in bed. R	lesident	#51 grabbed the left	•	:	•			

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		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 02/01/2018		
		495168						
NAME OF PROVIDER OR SUPPLIER					Ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHENANDOAH VALLEY HEALTH AND			REHAB			1737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	' MUST B	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE	(X5) COMPLETION DATE
F 700	Continued From pa	ge 30		F7	700			
		ft bed ra	ed to adjust her all was loose, moving ent pressed and pulled	- -		!		· .
		aring fo he loos sport the				i	· .	
	was interviewed ab- rail. The maintenar loose due to reside	out Res nce dire nt use a	maintenance director sident #51's loose bed ector stated the rail was and was tightened, was interviewed at this			· · · · · · · · · · · · · · · · · · ·		
	time about routine r checks for bed rails	mainter In the or state	ance and safety facility. The d he fixed loose bed				~	
:		erforme nt riske tarted e Novem	d on bed rails to				,	
	facility had quarter I the head of the bed stated older beds at	ength t s. The Iready	stated all beds in the bed ralls mounted near maintenance director had side ralls in place d for any new beds					
	check sheets titled Device Test Results	Bed Sy Works showin	presented a book of stem Measurement sheet. These sheets g potential entrapment					

7

PRINTED: 02/16/2018 . DEPARTMENT OF HEALTH AND HUMAN SERVICES FÖRM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND LAN OF CORRECTION IDENT)FICATION NUMBER: COMPLETED A BUILDING 495168 B. WING. 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB BUENA VISTA, VA 24416 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 700 Continued From page 31 F 700 zones (1 through 4) with spaces to indicate if the zone measurements met the recommended FDA gap measurements for safety or failed, indicating a potential entrapment risk. There were thirty-six bed rail safety assessments dated from 11/17/17 through 11/30/17. All thirty-six assessments presented by the maintenance director documented potential entrapment risks in one or more measured areas (zones 1 through 4). This included the beds of Residents #6, #7, #52, #56, #59, #60, #61, #63, #287. The maintenance director stated the facility borrowed a device for measuring the bed rail gaps and the measurements indicated failures on all the beds he checked. . When asked what actions were taken in response: to the failed tests, the maintenance director stated he was told near the end of November (2017) all the bed rails were to be removed. The maintenance director stated he then got word from nursing that the rails were not to be removed. The maintenance director stated the facility was "going back and forth" about using the bed ralls. The maintenance director stated the bed rails were currently still in place on resident beds. On 2/1/18 at 8:05 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed about bed falls and the maintenance assessments indicating entrapment risks due to gap measurements beyond the FDA recommended guidelines. The DON stated the facility borrowed a "tool" from another facility so

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the maintenance director could check the bed rail

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PRINTED: 02/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495168 B. WING 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB BUENA VISTA, VA 24416 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 700 Continued From page 32 F 700; gaps in response to the new regulations. The DON stated bed rails were not eliminated and rails were currently in place on all the facility beds. The DON stated residents had a quarterly nursing assessment that included a section on side rail use. The ADON stated the side rail assessment on the nursing assessment was "vague" and did not include specific assessments regarding entrapment risks. When asked what interventions had been taken in response to the falled gap measurement checks, the DON stated. "Nothing at this point," On 2/1/18 at 8:40 a.m., the administrator, DON and maintenance director were interviewed by the survey team concerning the bed rall assessments indicating entrapment risks. The maintenance director stated they borrowed a "too!" from another facility to assess if the bed rail gap measurements met the FDA requirements in zones 1 through 4. When asked if all the beds in the facility had been i assessed, the maintenance director stated, "No." †The maintenance director stated when he got ; word that the rails were going to be removed, he stopped performing the gap measurements because he saw no need to continue measuring if: the rails were going to be removed. This means that Residents #5, #8, #25, #35, #36, #42, #51, #58, and #83 beds were not evaluated for risk of entrapment, The maintenance director stated he stopped the bed rail assessments "at the end of November [2017]."

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The DON stated the rails weite left on the beds and nursing was supposed to evaluate each

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			/IDER/SUPPLIER/CLIA FIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			495168	B. WING			C 02/01/2018	
NAME OF PROVIDER OR SUPPLIER SHENANDOAH VALLEY HEALTH AND		TH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	. ID PREFII TAĞ	PROVIDER'S PLAN C (EACH CORRECTIVE AS CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X6) COMPLETION DATE	
:	understood the rails The DON stated th	d rail use vere indiv s were co e quarter ot incorpo	ridually assessed, she onsidered a restraint. ly nursing side rail orate anything about	:	100 :			
	related to the new r safety and was not assessments condi- asked if he informe corporate about the the 36 bed assessr director stated, "No asked again if anyon	remove a egulation in resport ucted in the distance in the distance in the distance in admit the in admit asset in asset in admit the in asset in a	all the bed ralls was as about bed rail has to the failed bed he facility. When ministrator or measurements for he, the maintenance think so." When ministration knew essments indicating					
· · · · · · · · · · · · · · · · · · ·	87 beds. The admi "moving toward" ge not made a decislo administrator stated	inistrator atting rid on to eliminate dishe had conducte	facility had a total of stated the facility was of bed rails but had nate rails. The I not seen the bed rail ed in November 2017				:	
	10:10 a.m. that sub identified related to and implement inte	cility was a standard the facilit rventions the facilit erformed nt risks d	advised on 2/1/18 at quality of care was ty's fallure to assess to ensure safe bed y. The thirty-six bed in November 2017 ue to gap					
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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PRO	VIDER/SUPPLIER/CLIA SEPICATION NUMBER:	(X2) MUL A. BUILOI	TIPLE CONSTRU NG	JCTION		DATE SURVEY COMPLETED
			495168	B. WING				C 02/01/2018
- '	PROVIDER OR SUPPLIER				3737 CATAL BUENA VIS	RESS, CITY, STATE, ZIP C PA AVE, PO BOX 711 STA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	the facility had not to no interventions impliassessed entrapmed facility including the survey sample did reassessments related risks and there were alternatives to bed re	e remain been ass blemente int risks. eighteen of have d specifi e no doc rail use.	n residents in the individualized bed rail cally to entrapment umented attempted maintenance director	F 7	00			
$\widehat{}$	guidelines regarding assessments for sa risks. The maintena not have a facility po dimension guideline These findings were	g bed rai fety inclusion direction ance direction but as for bed reviewed rector of	l audits or uding entrapment ector stated they did went by the FDA drail safety. ed with the nursing on 2/1/18 at					
	Bed System Dimens Guidance to Reduce 3 defines entrapment patient/resident is continued in the space in or at hospital bed frame. result in deaths and entrapment events I within the bed rails, mattresses, under be and between the be- boards. The popular	sional are Entrapent as, " aught, trapout the Patient serious nave occupet weer alls, drails aution moserly patien are fra	ment on pages 2 and an event in which a apped, or entangled bed rail, mattress, or entrapments may injuriesThese curred in openings and between split rails, and head or foot st vulnerable to nts and residents, il, confused, restless,					
DBM CMC OC	67(02-99) Previous Versions		- UD 640744		i			

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Facility ID: VA0223

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	TO TOTALISE DIONALE	- 171	DA 410 CE11410EO				<u> </u>	
			(IDER/SUPPLIER/CLIA (IFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BUILDING			(X3) DATE SURVEY COMPLETED	
			495168	B. WING			C 02/01/2018	
	PROVIDER OR SUPPLIER IDOAH VALLEY HEAI	TH AND	REHAB		STREET ADDRESS, CITY, ST 3737 CATALPA AVE, PO B BUENA VISTA, VA 244	OX 711	0210172010	
(X4) ID PREFIX TAG	. (EACH DEFICIENC)	y must be i	DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFIX TAG	(EACH CORRECT!) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ID TO THE APPROPRIATION ICIENCY)	(X\$) COMPLETION TE DATE	
F 700	Continued From pa movementLong-te majority of the entra pages 15 through 1 dimensional recom entrapment zones:	erm care apments. 8 docum		F 700				
۸.٬	the perimeter of the should be small end entering A loosen size of this space	rail. Op ough to p ed bar or recomm	any open space within enings in the rail revent the head from rail can change the end this space to be rs] (4 3/4 inches)"		· :			
	or next to a single r under the rail betwee the weight of a patie edge of the rail at a supports, or next to	ail - "This en mattr ent's head location a single his space	ess compressed by and the bottom between the rail rail support FDA be small enough to		:			
	area is the space be the rail and the mat weight of a patient's small enough to pre taking into account any lateral shift of the of play from loosened dimension of less the	etween the tress con the second the second he second he second the mattre second to the second the	pressed by the his space should be dentrapment when ess compressibility, and degree recommend a					
:		ap that fo ed by the f the rail,	orms between the patient, and the at the end of the rail.					
MAIL CRASS	57(02-99) Previous Versions	いりかいに任	Event ID: 64QZ11	Fa	cility IID; VA0223	If continuation	ahaat Daan de daa	

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PR IDE	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE SURVEY COMPLETED
			495168	B. WING_			C 02/01/2018
NAME OF	PROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP CO	
SHENAN	IDOAH VALLEY HEAI	.TH AN	REHAB		3737 CAT BUENA	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST B	OF DEFICIENCIES E PRECEDED BY FULL (IFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 700	Factors that may in mattress compress mattress or rail, and loosened rails. The entrapment of a parecommends that ti space also be less (1) (1) Guidance for Inseed System Diment Guidance to Reduct 2006. U.S. Departs Services Food and	crease dibility, led degree space sient's redune than 60 dustry a sional a e Entra ment of Drug A	ateral shift of the e of play from poses a risk for eckFDA nsional limit for this mm (2 3/8 inches)" and FDA Staff Hospital and Assessment	F 70			
	gulationandguldand 2729.pdf Free of Medication CFR(s): 483.45(f)(1	Error R	ncedocuments/ucm07 ts 5 Pront or More	F 7 5	9		
	percent or greater; This REQUIREMEN by: Based on medicati staff interview, and facility failed to ensi less than 5 percent 33 opportunities res rate of 6.06 percent Resident #56 had a (sliding scale insulin	sure the cation extreme on passed clinical ure a manufacture of the callting in the call in the ca	at its- rror rates are not 5 of met as evidenced s and pour observation, record review the edication error rate were two errors out of n a medication error		2.	Resident #56 rema facility. Physician medication error. without adverse o Identified nurse at on medication adreguidelines was con Residents receivin have the potential affected by this depractice	was notified of Resident utcome. nd education ministration mpleted g insulin could
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' CEIAIEI	TO POR MEDICARE	CKLIAIE	NOWIN SCUAIGES			<u> </u>	IŅB NO.	0938-0391
	OF DEFICIENCIES :	(X1) PRO IDE	ÖVÍDERVSUPPLIERVOLTA NTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		NSTRUCTION	COM	E SURVEY IPLETED
	•		495168	B. WING		INI. of MEANING A	1	C 01/2018
SHENAN	PROVIDER OR SUPPLIER				3737 C	T ADDRESS, CITY, STATE, ZIP CODE CATALPA AVE, PO BOX 711 IA VISTA, VA 24416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST B	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 759		-		F 759)	•		:
	his blood sugar was insulin was given	optain	ed and before his	·	3.	Licensed nurses will be	educate	ed
,	Findings were:	-				on the five rights of administration DNS/des		-
5	practical nurse) #2, 8:31 a.m., LPN # 2 for Resident #56. S room and did a fing reading was 335. L medication cart, ref prepared 12 units o administration. She room and administe food tray was obserbed. He was asked He stated, "Yes, ego LPN #2 returned to surveyor asked if the administered before	J2018 (beginn began she entick PN #2 erred to return ered the return for the figs, che the me e SSI ve or afte	with LPN (license ing at 8:10 a.m. At preparing medications ered Resident #56's blood sugar. The returned to the order and log insulin for ed to Resident #56's insulin. An empty at to Resident #56's ad eaten breakfast, erios, and apple juice."		4.	will conduct medication observation weekly to a medications are being administered per physic over the next three mo Results of audits will be Quality Assurance Performent for review recommendations for the months with Quality As Performance Improvem committee responsible ongoing compliance.	i pass essure tian ord hths. taken to rmance w and hree surance	20
. <i>.</i>	order and stated, "If	t is sup	She then reviewed the pose to be given before me changed on that."		5.	Corrective action will be conby March 1, 2018.	mplete	H
;	order was observed unit/mlInject as perscalesubcutaneous Type 2 diabetes me The above informat meeting with the add (director of nursing)	I: "Hun er slidin usly bef illitus! ion was ministr	g ore meals related to s discussed during a ator and the DON		edda ()			
į	exit conference on (02/01/2	018.	:	1			

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	OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTI A. BUILDIN		DNSTRUCTION .	(X3) DATE S	
			195168	B. WING _			02/0°	<u>1/20</u> 18
NAME OF	PROVIDER OR SUPPLIER			<u>' </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE) <u>VEIV</u>	175010
SHENAN	IDOAH VALLEY HEA	TH AND REH	IAR		3737	CATALPA AVE, PO BOX 711		
OILLIAN	DOMI VALLET I ILA	EIII AII DI IVEI			BUE	NA VISTA, VA 24416		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I		CEDED BY FULL	ID PREFIX TAG	1000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE :	(XS) COMPLETION DATE
F 803 SS≃E		ent Nds/Prep (1)-(7)	in Adv/Followed	· F 80 ·	3!		· 	<u>, </u>
	§483,60(c) Menus Menus must-	and nutritiona	al adequacy.		1.	Resident #59 remains in facility. Resident was pro	ovided a	
	§483.60(c)(1) Mee residents in accord guidelines.;	t the nutrition lance with es	al needs of tablished national			vegetarian menu and edi regarding proper protein consumption by the Diet	1	:
	§483.60(c)(2) Be p	repared in ac	Ivance;	; ; ;	2.	during survey.		
	§483.60(c)(3) Be followed:			1 de decembre - 1 de de decembre - 1 de decemb	۷.	Residents with vegetaria preferences can be affec		;
7	§483.50(c)(4) Reflet reasonable efforts, ethnic needs of the input received from groups;	the religious, resident pop	, cultural and pulation, as well as		3.	this deficient practice. Upon admission or chang dietary preference during stay, will be provided with	- g facility	
	§483.60(c)(5) Be u	pdated period	dically;			vegetarian menu and pro education on proper pro	ovided	:
	§483.60(c)(6) Be redictitian or other clip professional for nur §483.60(c)(7) Noth construed to limit the personal dietary chartis REQUIREMED by: Based on observainterview and clinic staff failed to provide	nically qualifititional adequing in this parties oices. NT is not metion, resident al record revide memus of controls.	ed nutrition uacy; and ragraph should be right to make et as evidenced interview, staff ew, the facility choice for one of			consumption. An audit residents' diets will be conducted on current research audits or residents' diets will also conducted for the next 3 months.	sidents. f be	
	22 residents in the Resident #59 was a choices based on h vegetarian.	not provided	with menu		tire of the contract of the co	•		

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TATEMENT OF DEFICIENCIES INDEXAN OF CORRECTION		VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495168	B. WING		C 02/01/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
SHENANDOAH VALLEY HEAL	TH AND	REHAB		3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416	`
C COLUMN CONTRACTOR CTA	TELATELIT O	E DEFICIENCIES			

<i>i</i>		495168	B. WING _			02/01/2018
	PROVIDER OR SUPPLIER	TH AND REHAB		3737 C	T ADDRESS, CITY, STATE, ZIP CODE CATALPA AVE, PO BOX 711 IA VISTA, VA 24416	`
デ(X4)ID ・ PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 803	Findings were: Resident #59 was at 12/15/2017 with the limited to: Major deptract infection, deger nervous system, and The admission MDS assessed Resident summary score of "cognitively intact. Resident #59 was in 1:25 p.m. regarding the interview, Reside vegetarian by choice	dmitted to the facility on following diagnoses, but not pressive disorder, urinary herative disease of the hypothyroldism. (minimum data set) #59 as having a cognitive 15", indicating she was terviewed on 01/30/2018 at her life at the facility. During ent #59 stated that she was a Resident #59 was asked	F 80	3 4.	Results of audits will be tak Quality Assurance Performs Improvement for review an recommendations for three months with Quality Assura Performance Improvement committee responsible for ongoing compliance. Corrective action will be completed on March 1, 201	ance
	what the facility was meet her protein ned came in and talked t circled several thing my mom could bring	providing her nutritionally to eds. She stated, "Someone of the stated of the stated," someone of the state o	ļ			
	01/30/2018. Her tra potatoes, green bea was asked what pro- lunch. She stated, " are my protein." Re- ate eggs or other da eat cheese, no eggs	pserved eating lunch on y consisted of mashed ns and joilo. Resident #59 tein she had been served for I guess the mashed potatoes sident #59 was asked if she iry products. She stated, "I just don't like them, but I are cooked in something,"				
	at approximately 3:0 physician order shee	ras reviewed on 01/30/2018 0 p.m. The diet order on her et was, "Regular". The care There were no interventions			· .	

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STATEMENT OF DEFICIENCIES AND ALAN OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUL A. BUILC		E CONSTRUCTION	(X3) DATE S	
						c	
		495168	B. WING			02/01	/2018
NAME OF PROVIDER OR SUPPLIER		NE DELIAES			TREET ADDRESS, CITY, STATE, ZIP CODE 737 CATALPA AVE, PO BOX 711		
SHENANDOAH VALLEY HEAL	.1 17 2	ND KERAD		8	UENA VISTA, VA 24416		
PREFIX (GACH DEFICIENCY	MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE .	(X5) COMPLETION DATE
in the clinical record Form" dated 12/19/manager. Commen were: "Please do n vegetarian, per residual to the dietary manager that she had only be days. The regional he was not familiar the RD (regional die The RD was intervie a.m. The RD stated Resident #59 she divegetarian. The RD requisition form that 12/19/2017. The RI form should have predicted that resident's checould not find any dehad occurred. The Fifsh was on a "Choice picked what she was menu. The RD was ensured that Reside protein needs, since mashed potatoes as stated, "She makes me to make sure she The RD was asked example of the men make her meal chole and returned with a contained a meat che was: "WEDNESDAY vegetable blend, con	reger was: 1 value of the control o	arian status. Observed a "Diet Requisition and signed by the unit the bottom of the sheet and meat. Resident is a request." eyor asked to speak with the dietary manager stated at the facility for three ary manager stated that the resident, however, in) was in the building. I on 01/31/2018 at 10:15 to when she first met with the mention that she was a saked about the dietary sent to the kitchen on ated that the requisition ated that the requisition ated a visit by the DM to so She stated that she mentation that the visit continued that Resident enu", meaning she to eat by circling it on the ated how the facility sident #59 had Identified rotein source. The RD own choices, it isn't up to making good choices." The RD left the room up the RD left the room up. Each meal listed so Listed for Wednesday INER: Chicken chili,	F {	303			

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	FOF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		ATE SURVEY OMPLETED
			495168	B. WING				C 2/01/2018
	PROVIDER OR SUPPLIER		REHAB		STREE 3737 C BUEN		210112018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST B	OF DEFICIENCIES PRECEDED BY FULL IFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Tossed salad with dressing, SIDE D beans, mashed power what the protein of the for Resident #5 offer cottage cheemenu she present vegetarians since protein was cottag she would go and her diet and her cheemens with the since protein was cottagen would go and her diet and her cheemens.	HOT SA Dog, seburger WAYS A' ranch, fi ISH Cot otato" hoice list ie. She: se". The ed was g the only e chees speak w noices.	Grilled Cheese, VAILABLE SALAD ench or Italian tage Cheese, green The RD was asked ed on the menu would stated, "We always RD was asked if the geared towards item listed for them for a. The RD stated that ith Resident #59 about	. F8	303			
· · · · · · · · · · · · · · · · · · ·	got this one last wo circled what she w good protein choic	D p.m. Si "Lacto-Ced, "I me we went eek to ch eants. I a es."	ne presented a Dvo Vegetarian" It with [name of over this menushe					
F 81.2	meeting on 01/31/ No further informa exit conference on Food Procurement	2018. tion was . 02/01/2 t,Store/F	obtained prior to the		312			
> 5≃E	CFR(s): 483.60(i)(§483.60(i) Food sa The facility must – §483.60(i)(1) - Pro approved or consider	afety req			1.	Muffin pans and tray removed from shelf, and air dried per poli survey.	re-sanitiz	
-ORM CMS-25	: 567(02-99) Previous Version	s Obsolete	Event ID:64QZ1	i	Facility ID	D: VA0223 If cont	Inimilan eta	of Page 42 of 5

PRINTED: 02/16/2018

	TMENT OF HEALTH RS FOR MEDICARE		1					FORM	APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PRO IDEN	VIDER/SUPPLIER/CLIA VIIFICATION NUMBER:	1			RUCTION	COM	E SURVEY IPLETED
			495168	B. WING _					C /01/2018
NAME OF F	PROVIDER OR SUPPLIER				STR	EETAI	DDRESS, CITY, STATE, ZIP CODE		
SHENAN	IDOAH VALLEY HEAL	TH AND	REHAB				ALPA AVE, PO BOX 711 VISTA, VA 24416		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE	OF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG		(CR	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL COSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	Continued From pa	-		F 81	12		<u> </u>		
			ms obtained directly	i	2		Sanitized trays and muff	in pans	i
			ct to applicable State		_	•	have the potential of be		
	and local laws or re (II) This provision do	gulation ses not	s prohibit or prevent	i (1			affected by this deficien		
	facilities from using						practice.	_	
	safe growing and fo	compile	ance with applicable		3	3.	Education to dining staf		
;	(iii) This provision d						proper air drying of tray	s and	
			procured by the facility.	ļ			muffin pans will be prov		y
	•		,				the Dining Manager. A		•
	§483.60(i)(2) - Store	e, prepa	re, distribute and	:					
	serve food in accord			•			will be conducted week		
_ :	standards for food s			i ·			monitor proper storage	of	
7	This REQUIREMEN by:	∜T is no	ot met as evidenced				sanitized dishes over th		3
			ff interview, and facility	!			months.		
i			y failed to ensure pans	! !		4.	Results of audits will be	e taken	to
;		d and d	ried were not nested	1		٦,	Quality Assurance Perf		
	wet.								, ,
: }	Findings include:						Improvement for revie		
	Tango moray.						recommendations for	three.	
, ,	The kitchen was ins	pected	1/30/18 beginning at				months with Quality A	ssuranc	:e
	10:35 a.m. with the	Dietary	Manager (DM) and	•			Performance Improve		
	regional dietary mai	nager.	During the Inspection,	1			committee responsible		
	the regional dietary	тапад	er was asked to	İ				2 , 2 .	
			et pans, identified as use. The regional				ongoing compliance.		
			op three of 10 sheet	i	•	5.	Corrective action will	pe	
. !			wet. This surveyor				completed on March	1, 2018	
			ans be lifted, and two						
			t. The DM removed	!					
i 1	the wet pans and pu	ut them	to be washed. The	į					
	regional dietary mai	nager w	as then asked to lift a	İ					
į	stack of muffin pans	s, also i	dentified as clean, dry,		:		•		
	and ready for use.	Two of	he seven muffin pans	ļ					
:	were nested wet. T	he DM	also removed those	•					

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pans to be washed.

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Facility ID: VA0223

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	OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIF		NSTRUCTION		E SURVEY MPLETED
			495168	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER				STREE	T ADDRESS, CITY, STATE, ZIP CODE	02	/01/2018
SHENAN	IDOAH VALLEY HEAL	TH AN	D REHAB	3737 CATALPA AVE, PO BO BUENA VISTA, VA 2441		CATALPA AVE, PO BOX 711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST E	OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BΕ	(X5) COMPLETION DATE
F 812	Continued From pa	ge 43		F 81:	2			
7 1	beginning at 3:45 p asked if there was a kitchen; she stated On 1/31/18 a policy presented to this su Statement" of the p policy to insure (sic ware that is not pro machine will be was "Action Steps" was Services Director in ware and cookware No further Informati exit conference. Administration CFR(s): 483.70 §483.70 Administra A facility must be ac enables it to use its efficiently to attain o practicable physical well-being of each in This REQUIREMEN by: Based on survey fit the facility administra administration to pro care in the area of 0 Findings were:	m, the a policy she was "Manu riveyor olicy sto all se cessed and docum sures are air on was fion. It is resour main, mentices are factor fact	lai Ware Washing" was The "Policy ated "It is the center vice ware and cook I through the dish and sanitized." Under ented "3. The Food (sic) that all service r dried to storage." s provided prior to the ered in a manner that rces effectively and tain the highest al, and psychosocial t, tot met as evidenced and staff interviews, illed to provide effective substandard quality of of Care.	F 83:	1.	Physicians for Residents #5, #8, #25, #35, #36, #42, #51, #56, #58, #59, #60, #61, #63, and #287 will be notified of eresident who was found to have received substandard quality during survey. A certified let the State Board of Licensure sent by the Administrator to of substandard quality of carsurvey. Residents residing in the facility and the potential to be affective and the potential to be affective.	#52, #83, each ave of car eter to will be notify re duri	re e ng
			ducted from 01/30/2018 g the survey deficient	i		have the potential to be affer this deficient practice.	cted b	У
FORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 64QZ11		acility if	D: VA0223 If continuati	on sheet	: Page 14 of 51

PRINTED: 02/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PRÓVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495168 B. WING 02/01/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE, PO BOX 711 SHENANDOAH VALLEY HEALTH AND REHAB **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 835 | Continued From page 44 F 835: practice was identified in the area of quality of 3. Education will be provided to care, at F700 with a scope and severity level of 2, administrative team regarding wide spread regarding the facility's failure to ensure all beds in the facility were in compliance appropriate reporting to the with risk areas of bed entrapment. Administrator. New company/CMS Substandard quality of care was initiated on policies will be reviewed and 2/1/18. During the process, interviews took place implemented as they are with the administrator, regional clinical director disseminated with any action items and the director of nursing. The regional director and follow-up identified. verbalized that maintenance did not inform the administrator or clinical director of the beds not 4. Administrator will review TELS being in compliance (the administrator agreed). (electronic maintenance logs) on a DON verballzed that she was informed of the monthly basis with results reported concern with the bed rails but related the concern with the bed rails being a problem in terms of on a monthly basis during Quality restraints, not in terms of the bed rails were out of Assurance meeting/ QAPI and any compliance for entrapment. immediate action items will be The administrator verbalized that she should followed up on during daily stand have been made aware of the concern so that she could have complied with the regulation. down meetings. Corrective action will be 5. No further information was provided prior to the completed on March 1, 2018. exit conference on 2/1/18. F 909 Resident Bed F 909! SS=F | CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bod frame, the facility must

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frame are compatible.

ensure that the bed rails, mattress, and bed

This REQUIREMENT is not met as evidenced

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Fadilly ID: VA0223

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by:

	HAITH OF HEVELU		1	•			FORM APPROVED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	RS FOR MEDICARE		1				MB NO: 0938-0391
STATEMENT AND FLANC	OF DEFICIENCIES OF CORRECTION	(X1) PRO	MDER/SUPPLIER/CLIA VIFICATION NUMBER:	A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	<u>-</u>		495168	B. WING	-	<u> </u>	C 02/01/2018
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0210112018
		٠				GATALPA AVE, PO BOX 711	
SHENAN	DOAH VALLEY HEAL					NA VISTA, VA 24416	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE	OF DEFICIENCIES FPRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIQUE
E 909	Continued From pa	ao 45			20		
1 505			of landaring facts of a still to	្ កម	09!		
			ff interview, facility al record review, the		7.	Resident #51 remains in the f	acility
;-			et routine inspections			The loose bedrail for resident	:#51
	of beds and/or bed	ralls thr	oughout the facility to		\	was repaired during survey.	The 36
			ntrapment. Bed rall		`	beds identified at risk of entra	10 A 10 A
	assessments of thir indicated risks of er					will be assessed for replacem	
			se recommended by			•	1 .
	the Food and Drug.	Adminis	tration (FDA). There	;		and/or repaired. The remain	- 1
			emented in response to	}.		beds in the facility will be ass	1
			ze and/or ellminate	: 		for risk of entrapment potent	ial with
	entrapment risks fro remaining fifty-one		s in the facility were	: 		appropriate repairs or replace	ements
			nt risks. There was no	:		as needed.	
	facility policy or pro-	gram eş	tablished for regular		_ 2.	Beds in the facility have the	ļ
			to Identify potential			potential to be affected by th	de .
	areas of entrapmen	t. '		, 188 0		•	15
	The findings include	٠. بد	, ef-	भ		deficient practice.	3
	i i i i i i i i i i i i i i i i i i i	,			:. 3.	Education will be provided by	<i>f</i>
	On 1/30/18 at 11:17	'a.m.,	Resident #51 was		· •	DNS/designee to report loose	:
	observed in bed. R	esident	#51 grabbed the left			bedrails to Maintenance for r	epairs
	quarter length rail o positioning. The lef	n ner og t bed r	ed to appost ner iii was loose, moving		er C	and adjustments. Audits will	be
	back and forth as th	e resid	ent pressed and pulled		₹. ₩	done 5x weekly during Care k	(eeper
•	on the rail.			•		Rounds to ensure bedrails are	
,	On 1/30/12 at 11:07		he licensed practical			loose. Maintenance will com	
			r Resident #51 was				•
	interviewed about th			!		monthly audits on beds to ide	•
	stated she would re					loose side rails needing repai	
	maintenance directe	or.			4.	Results of these audits will be	taken .
	On 2/1/18 at 9:00 a	m tha	maintannes dissets:			to Quality Assurance for revie	ew and .
			maintenance director Ident #51's loose bed	İ		recommendation for three m	onths
			ctor stated the rail was	İ		with the QAPI committee	
	loose due to resider	nt use a	and was tightened.			responsible for ongoing comp	alianco
	The maintenance d	irector \	was interviewed at this				
	time about routine r	nainted	ance and safety	!	5.	Date of completion March 1,	2018.

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time about routine maintenance and safety

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	RS FOR MEDICARE		ICAID SERVICES				ΟŃ		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	N		(X3) DATE	E SURVEY PLETED
	•		495168	B. WING					⊃ 01/2018
NAME OF	PROVIDER OR SUPPLIER			.		S. CITY, STATE, ZIF	CODE		
SHENAN	IDOAH VALLEY HEAI	TH AND	REHAB		3737 CATALPA A BUENA VISTA,				
· (X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BI	OF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	PREFIX	. (EACH C	PIDER'S PLAN OF C CORRECTIVE ACTIVE EFERENCED TO THE DEFICIENCY	ON SHOULD I HE APPROPR	₿Ę	(X5) COMPLETION DATE
E 000	Conflored France	40		:					
1. 202	Continued From pa			F 90	91				! :
	checks for bed rails			:	_		- <u>-</u>		
			d he fixed loose bed						
	; rails when there wa : asked if any souting	is a repr seefato	orted problem. When checks or inspections	[•	
	were performed on	bed rai	is to minimize						
	entrapment risks, ti	he main	tenance director stated						
			ails for entrapment						
			response to the new						
			nce director stated all	1					
			rter length bed rails	į.					
_	mounted near the h	read of	the beds. The						
			d older beds already	! . ! .					
	had side rails in pla								
	installed for any ne								
40			nted a book of check						
			leasurement Device						
			hese sheets had a htial entrapment zones						
	(1 through 4) with s	ng pole naces f	o indicate if the zone	! 1					
	measurements mai	the rec	ommended FDA gap	· !					
			r failed, Indicating a						•
			There were 36 bed rail						
			from 11/17/17 through	1					
			essments presented by						
	the maintenance di	rector d	ocumented potential		-				
	entrapment risks in	one or	more measured areas		•				
	(zones 1 through 4)). The r	naintenance director	ļ					
	stated the facility bo			,					
	measuring the bed			į					
			allures on all the beds	•					
	he checked. When			i					
į	taken in response t			!					
			d he was told near the	1					
;			I the bed rails were to						
:			ance director stated he						
į			that the rails were not	İ				*	
;			enance director stated	1					
:			and forth" about using	<u> </u>	•			,	
	ing boolighs, TUG (namten	ance director stated	!	-	•			

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the bed rails. The maintenance director stated

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	OF DEFICIENCIES OF CORRECTION		VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	(X2) MULT A. BUILDI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
1	,		495168	B. WING		-	C 02/01/2018
	PROVIDER OR SUPPLIER		REHAB		STREET ADDRESS, CITY, STAT 3737 CATALPA AVE, PO BOX BUENA VISTA, VA 24416	X 711	V2.01.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE COMPLETION
	Continued From pa the bed rails were or resident beds.		still in place on	F 9	09		
	were interviewed at maintenance assessives due to gap me recommended guid facility borrowed a the maintenance digaps in response to DON stated bed rails were currently beds. The DON stated bed rails assessment on the "vague" and did not regarding entrapment interventions had be	nt director bout bed sements easurem felines. "fool" from rector contract the new fin place and that include entrisks, een take ment che	r of nursing (ADON) ralls and the indicating entrapment ents beyond the FDA The DON stated the n another facility so uld check the bed rail regulations. The not eliminated and on all the facility dents had a quarterly luded a section on ated the side rail assessment was specific assessments				
	On 2/1/18 at 8:40 a and maintenance d survey team concerindicating entrapmed director stated they another facility to as with bed rails met that through 4. When facility had been as director stated, "No stated when he got to be removed, he smeasurements becomes and maintenance of the state	.m., the a lirector worning the entrisks. borrowe seess if go asked if sessed, "The moord that stopped ause he if the ra	d a "too!" from pap measurements equirements in zones all the beds in the the maintenance raintenance director at the rails were going performing the gap saw no need to				
i	removed. The mair 57(02-99) Previous Versions		Event ID: 640Z11		Eacility ID; VAG223	lé anntinunt	in theat Page 49 of 54

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDI	CAID SERVICES					VI APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PRO			VIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION		TE SURVEY
PND PLAN (OF CORRECTION	IDEN.	TIFICATION NUMBER:	A. BUILD	ING _			MPLETED
<i>/ /</i>								С
			495168	B, WING			07	2/01/2018
NAME OF	PROVIDER OR SUPPLIER			1	\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHENIAN	IDOAH VALLEY HEAL	TH AND	DEUAD	1	37	737 CATALPA AVE, PO BOX 711		
SHEWAR	OUAH VALLET HEAL	.IO AND	RENAB		В	UENA VISTA, VA 24416		
(X4) ID	SUMMARY STA	TEMENT O	F DEFICIENCIES	· ID	į	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG			PRECEDED BY FULL YING INFORMATION)	PREFO TAG	Χį	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES		(X5) COMPLETION DATE
11.745	; ;				;	DEFICIENCY)	AMIC	Ditte
***				:	;			
F 909	Continued From pa	ne 48	,	E 0	09			•
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· The state of the	stopped the bed rail assess		. гэ	1 Ç U			
r!	November (2017)."			:	•			
			rsing was supposed	:				
	to evaluate each re			i :				
	The DON stated un				:			
	individually assesse			,				
en ∮			The DON stated the					•
•	quarterly nursing sid							
	incorporate anything							•
	measurements perf	ormed b	y maintenance. The					:
	maintenance director							
			all the bed rails was					
	related to the new re				:			
			ise to the failed bed					
\triangle	assessments condu			!				
/ \	asked if he informed			:				
			ap measurements for					•
			ne, the maintenance	•				
	director stated, "No.							
in G	asked again if anyon					·		
	entrapment risks, th		essments indicating	•				
			ator stated the facility					
:	had a total of 87 her	ds The	administrator stated					
			ard" getting rid of bed		:			
·	rails but had not ma							
			ed she had not seen		:			
:	the bed rail assessn	nent she	ets conducted in		:			
	November 2017 ind							
:					;			
;			maintenance director					
:	was interviewed abo	out any f	acility policy or	•				
	guidelines regarding							
!	assessments for sat							
į	risks. The maintena							
	not have a facility po	olicy but	went by the FDA					
	dimension guideline	s for bec	l rall safety.		•	•		

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; These findings were reviewed with the

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	TMENT OF HEALTH		· -				FORM	0: 02/16/2018 MAPPROVED		
			/IDER/SUPPLIER/CLIA TEICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				DMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
, ,			495168	B. WING		·	l ns	C 2/01/2018		
	PROVIDER OR SUPPLIER IDOAH VALLEY HEAL	TH AND	REHAB		373	EET ADDRESS, CITY, STATE, ZIP CODE 7 CATALPA AVE, PO BOX 711 ENA VISTA, VA 24416	<u> U</u>	201/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE]	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREF TAG	ıx ;	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5I COMPLETION DATE		
F 909	10:10 a.m. and duri 2:30 p.m. The Guidance for Ir Bed System Dimensions of the System Dimensions of the System Dimensions of the Space in or all hospital bed frame. The System of the	irector of ng a med adustry a sional and e Entrap nt as, " aught, tra- cout the Patient serious have occubetween between between bet rails, a d rails are ition mos erly patie o are frai rolled bo erm care pments.	nd FDA Staff Hospital of Assessment ment on pages 2 and an event in which a apped, or entangled bed rail, mattress, or entrapments may injuriesThese curred in openings the bed rails and between split rails, and head or foot sit vulnerable to ints and residents, t, confused, restless, dy facilities reported the" This reference on	F\$	309					
:	dimensional recommentrapment zones: Zone 1 - Within the the perimeter of the should be small end entering A loosenesize of this space less than 120 mm [recommendations]	rail - "a rail - "a rail. Op ugh to p ed bar or recomme nillimeter rail betwee ail - "This en mattre int's heac	any open space within enings in the rail revent the head from rail can change the end this space to be so [4 3/4 inches]" een the rail supports space is the gap ess compressed by d and the bottom between the rail							

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Event ID: 640Z11

Facility ID: VA0223

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STATEMENT OF DEFICIENCIES (X1) PF AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SU	JPPLIËR/CLIA ON NUMBER:	1	IPLE CONSTRUCTION	(X3) C	(X3) DATE SURVEY COMPLETED	
,		495	168	B. WING				C 2/01/2018
	PROVIDER OR SUPPLIER IDOAH VALLEY HEA	}			STREET ADDRESS 3737 CATALPA A BUENA VISTA,	VE, PO BOX 711	P CODE	210 1120 18
(X4) ID SF PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECED LSC IDENTIFYING INF	ED BY FULL	PREFIX TAG	(EACH C	IDER'S PLAN OF C IORRECTIVE ACTI EFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 909	Continued From parecommends that prevent head entra 3/4 inches)"	this space be sm		F 90	39	•		
	Zone 3 - Between area is the space to the rail and the ma weight of a patient small enough to pr	petween the insidu attress compress 's head. This sp revent head entre	de surface of ed by the ace should be apment when					
	taking into account any lateral shift of of play from looser dimension of less to because the head before the neck"	the mattress or r red ralls,recom than 120 mm (4	all, and degree mend a 3/4 inches)		:	·		
	Zone 4 - Under the "This space is the mattress compress lowermost portion Factors that may in mattress compress mattress or rail, an	gap that forms beed by the patier of the rall, at the norease the gap sibility, lateral shid degree of play	etween the it, and the end of the rail. slze are: ift of the from					
	loosened rails. The entrapment of a parecommends that to space also be less (1)	itient's neckFD the dimensional l	A IlmIt for this		:			
Na Signatura de la Carta de la	(1) Guldance for In Bed System Dimer Guidance to Reduc 2006. U.S. Depart Services Food and www.fda.gov/down gulationandguidand 2729.pdf	nsional and Asse be Entrapment. Me ment of Health a Drug Administra loads/medicalde	ssment March 10, and Human ation. 2/2/18 vices/devicere		:			
ORM CMS-25	67(02-99) Previous Versions	5 Obsolete	Event ID:64QZ1	.1	Facility ID: VA0223		If continuation she	et Page 51 of 51

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